State Exchanges: Issues for Consideration

Comments to the NAIC Exchanges (B) Subgroup
Thursday, August 12th 2010

Introduction:

Recently, the Department of Health and Human Services (HHS) released a request for comment regarding the Exchange-related provisions of the Affordable Care Act (ACA) in advance of future rulemaking.[1] This request was released in conjunction with an announcement that grants of up to $1 million per state are available to help begin the work of establishing Exchanges.

A key theme coming through this request is the question with respect to whether states will be prepared to have the necessary infrastructure in place by January 1, 2013 to start an Exchange or "opt-in" to a Federal model, and the related balance of federalism in determining federal versus state functions.

We recognize that while ACA provides for the core functions an Exchange must perform, which we outline in the next section, there is wide discretion left to the states at this stage to define the structure and build an effective consumer-focused model that stimulates competition. As states move forward to build Exchanges, we emphasize four fundamental principles that are critical:

1. **Exchanges should supplement but not replace existing markets and regulatory functions should not be duplicated.**

2. **Exchanges should offer consistent and objective participation criteria to allow for meaningful choices to consumers.**

3. **Mechanisms should be established that ensure increased participation and mitigate risk selection both inside and outside of the Exchange market.**

4. **Ensure to the extent appropriate, uniform standards by which data elements are used to ensure that consumers have access to useful, accurate and understandable information**.

As states are working through the many and inter-related issues central to an effective we appreciate that the NAIC has initiated this discussion with a thoughtful and reasoned approach that is necessary to evaluates the potential interactive effect that each individual design feature has with other design elements and the potential for unintended consequences. Given the potential impact, we strongly encourage an approach that evaluates the potential interactive effect that each individual design feature has with other design elements and the potential for unintended consequences. For example, as we advocated throughout health reform, we share the Commissioner's concerns about adverse selection, and assessing the range of issues, both inside and outside of the Exchange. The health plan community stands ready to be a resource to and engage in partnerships with states to develop solutions that address structural, policy and technical challenges that will need to be navigated to ensure the development of workable structures that fulfill the promise of the legislation.

To that end, we recommend that states consider passing legislation that requires the establishment of a special health insurance Exchange committee to conduct a study that carefully evaluates policy objectives

[1] "45 CFR 170: Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act." Text from : *Code of Federal Regulations* (August 3, 2010--FR Doc. 2010-18924).

including deficiencies in the current market that an Exchange seeks to address, key design and structural elements necessary to meet those objectives and states' readiness to build what is required. We recommend that this committee has multi-stakeholder representation across both the public and private sector. Recently, states such as Mississippi, Nevada and New Mexico have passed such legislation with the objective of framing the challenges, evaluating the salutations and providing specific recommendations to their legislators in advance of building Exchange structures.

States that have already built Exchanges, including Massachusetts and Utah, spent years developing a model that works for their particular market. Indeed, crafting a strategy unique to a specific marketplace requires adequate assessment to ensure that duplicative regulatory frameworks are not created and any perceived inadequacies of a market are addressed. For instance, when Massachusetts undertook the task of developing the first of its kind Commonwealth Connector, extensive analysis of the state's market showed that any successful Exchange structure needed provide increased access to subsidized coverage for those already eligible but not enrolled. With this in mind, the Commonwealth Connector included a platform specifically aimed at connecting eligible individuals with available public subsidies, leading to enrollment of more than 170,000 only eighteen months after launch. In Utah, planning and development for the Utah Health Exchange began nearly two years before the Exchange undertook its first limited launch phase. Convening stakeholders early in the development process permitted the discussion and consideration of the factors of the concerns which the Exchange was seeking to address. This knowledge led to a platform that was uniquely tailored to the concerns facing the Utah marketplace, the need for direct access to coverage for small employer groups and greater consumer involvement in individual coverage decisions.

The following provides background on the core functions an Exchange must establish as the foundation required by ACA. In response to the NAIC's discussion of Exchange issues, we highlight a series of key issues that are most critical when considering the architecture of the Exchange and have provided recommended principles to consider in each of these areas.

We commend the NAIC for undertaking its work on this critical reform issue and encourage the development of a Model Law that will help to guide states toward Exchange implementation that is practical, thoughtful and timely.

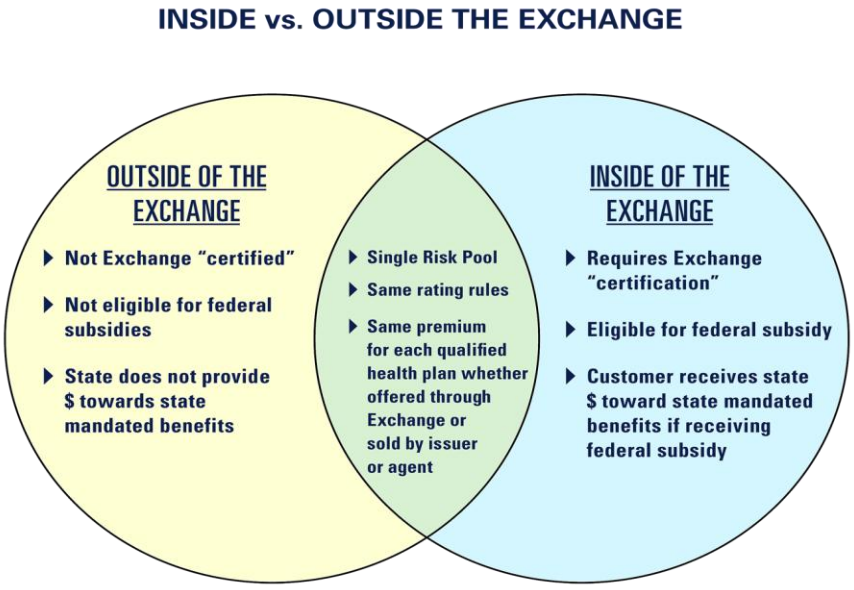
ACA Requirements:

The flexible Exchange structure in the ACA provides an opportunity to respond to the unique circumstances in each state, but requires a thorough assessment of state markets and a review of the ACA Exchange requirements. States will want to consider the following key elements of the ACA's Exchange provisions:

1. ACA established a system recognizing that health care is provided locally. Therefore, it makes sense to premise the Exchange provisions on the notion that states are given the "first cut" at establishing exchanges to be operational in 2014. If a state fails to establish an exchange or the Secretary determines, by January 1, 2013 *or sooner,* and a state has either failed to implement ACA-directed insurance market reforms or will not, in the Secretary's judgment, be able to begin operating an Exchange by the January 1, 2014 deadline, the Federal government will establish and operate an Exchange in the state.

2. Exchanges will operate in a post-2014 reform environment with comprehensive market reforms in both the Exchange and outside markets, including a requirement of guaranteed issue to all individuals, no pre-existing condition exclusions, no risk-rating based on health status and limited rating based on age (3:1 rating band) and tobacco use (1.5:1).

3. Health insurers must include all enrolled individuals both inside and outside of the Exchange market in a single risk pool and all enrollees in the small group market in a single risk pool.



Differences and Overlap Outside of and Within the Exchange

4. Exchange participating "qualified health plans" (QHPs) must meet specific certification requirements as outlined in the law in order to be offered through the Exchange, and, more broadly, generally be deemed "in the interests of qualified individuals and qualified employers in the State or States in which such an Exchange operates".
    a. Specific certification criteria apply to the following areas:
        i. marketing practices;
        ii. network adequacy (ensure a wide-choice of providers – including certain essential community providers, where available, that serve predominately low-income, medically underserved individuals);
        iii. accreditation (e.g., clinical quality measures such as the HEDIS and CAHPS Survey and patient information programs);
        iv. quality improvement strategies that incorporate a payment structure that provides increased reimbursement and other incentives;
        v. uniform enrollment forms;
        vi. standardized format for presenting plan options;
        vii. quality measures for health performance endorsed under the Public Health Services Act;

5. Internet portals established under the law to facilitate health insurance choices must provide detailed, federally-prescribed information on available plans based on a federal template. The portals are also required to rate plans on quality metrics using guidance developed by the Secretary.

6. To this end, exchange-offered plans will be required to make information in the following areas available to the Exchange, the Secretary, the State and the general public:
    a. Claims payment policies and practices
    b. Financials
    c. Enrollment/disenrollment
    d. Claim denials
    e. Rating practices.
    f. Cost-sharing and out-of-network charges
    g. Enrollee and participant rights
    h. Other information as determined appropriate by the Secretary

7. The Secretary will require Exchanges to establish enrollment periods including an initial open enrollment period, annual open enrollment periods and special enrollment periods for plans offered through the Exchanges.

8. Subsidies are available only through the Exchange, not available through the outside market.

9. Exchanges must be self-sustaining beginning on January 1, 2015 and Exchanges may charge assessments or user fees to participating health insurance issuers.

10. Creation of other market options through the Exchanges include Co-Ops, multi-state plans and a basic health program for low-income individuals not eligible for Medicaid (up to 200% FPL).

Fundamental Principles for Implementation of Exchanges:

1) Exchanges should supplement but not replace existing markets and regulatory functions should not be duplicated

Regulatory authority of Exchange. As captured in the HHS request for comments, one key issue to consider is the extent to which the Exchange should act as a regulator, or leave regulation/enforcement to existing agencies to the Department of Insurance or the Federal Government. We believe that it would be both unnecessary and costly to establish a separate Exchange regulatory framework. Generally, this role should be limited to ensure that competition is strong in the new market (see additional detail below) and to limit the establishment of unnecessary and costly parallel regulatory frameworks when States could consider encouraging the leveraging of existing state agencies, expertise, processes and structures in order to ensure administrative efficiency. This model would serve to complement functions of the existing marketplace and the

Exchange while ensuring a better experience for the consumer. States must also contemplate the potential for duplication of oversight from the Federal government and the consequences that may have when establishing an effective and efficient Exchange market.

Inside versus Outside Market. Related to regulatory oversight, we would encourage the establishment of a level-playing field by requiring health plans offered inside the Exchange to meet the same market regulations that apply to plans offered outside of the Exchange. To that end, it is extremely important that Exchanges be structured in such a way as to enhance consumer options by supplementing, but not replacing, the current market. This should be done to ensure that individuals and small groups can continue to purchase coverage outside of the Exchange as well as inside the Exchange to help avoid selection issues across the markets, and limit unintended consequences that could undermine support for the new market.

Governance. In order to ensure a level of independence and public transparency, States should consider the creation of a non-profit or quasi-government entity with a Board of Directors that would serve to govern the operations of an Exchange. In order to ensure public transparency, the Exchange should have representation across a variety of stakeholders including health plans, consumer representatives, the employer community and other stakeholders. The quasi-government approach supported by a range of stakeholders will also ensure that exchange rules support the key functions outlined in the statute.

2) Exchanges should offer consistent and objective participation criteria to allow for meaningful choices to consumers

Maximizing Consumer Choice with Strong Competition. While ACA establishes specific certification requirements for qualified plans to participate in the Exchange, there is no requirement that Exchanges must establish a "bidding" or other such system for plans to participate. The process by which plans are reviewed and approved to participate in the Exchange is a flexible area in which States must balance interest in ensuring that plans meet certain standards while at the same time preserving a robust marketplace that encourages choice and innovation.

In order to maximize consumer choice, Exchanges should establish clear criteria for participation. Participation criteria as outlined by ACA should be built upon existing standards to the extent possible and not based on subjective determinations by the states or Federal government.

Much as the health plan community wants to maximize broad and early participation among individuals and small business to ensure there is a balanced pool of newly insured individuals, we also want to ensure there is strong participation among competing plans. In summary, we are very concerned that additional requirements, particularly those that are subjective will lead to a less robust and effective exchange.

Transparency. As states work to create an Exchange market that allows for robust competition and consumer choice, there should be a focus on providing consumers with clear and transparent information with display of all factors that are critical to consumer decision-making including price, quality, networks, cost-sharing design and benefits. This overarching goal toward enhanced transparency does however, require a careful balance with rules designed to prevent price "signaling" and disclosures that will limit market competition.

3) Mechanisms should be established that ensure increased participation and mitigate risk selection both inside and outside of the Exchange market

There are several structural elements that serve to mitigate risk selection both inside and outside of the Exchange environment including a temporary reinsurance program, risk corridors and a risk adjustor. The adequacy of these elements is critical to mitigate the potential for strong risk selection both inside and outside the Exchange. Regulators must establish methodologies that ensure a stable and seamless experience to the consumer whether accessing coverage inside or outside of the Exchange, while protecting against undue risk selection. In particular, we urge caution in assessing the impact of the exchange market on the existing employer market relating to adverse selection, and incentives to ensure that those offering employer coverage continue to do so.

4) Ensure to the extent appropriate, uniform standards by which data elements are used to ensure that consumers have access to useful, accurate and understandable information

There are several key functions in which Exchanges and health plans will play an integral role including enrollment of individuals and employers participating through an Exchange, the billing of individuals or employers for services rendered, premium collection, the coordination of premium subsidies, call centers and the managing of distribution channels such as websites and broker relationships to facilitate the consumer experience.

Health plans will also provide product descriptions and pricing information that will inform the consumer and allow for the comparison of health plans and products prior to making a purchasing decision. Health plans' provider networks will be a key element of criteria to participate in Exchanges. Health insurance companies offer a range of program options and provider networks which will provide a basis for consumers to compare the options available. States should be inclusive in the types of network-based programs eligible to be qualify for participation in the Exchange as a means of assuring robust product offerings both inside and outside the Exchange structure.

Addressing these functional elements will raise a number of key data administration issues. First, the coordination and transmittal of data is a complex undertaking including a dynamic interface with agencies at both the state and federal level including the HHS, IRS, Medicaid and Social Security, as well as with the various health plans. The technical architecture and secure communication protocols needed to seamlessly transmit data elements will need to be carefully considered and provide for consistency among the states by conforming to generally accepted data, communication, and encryption standards. We are concerned, for example, that many states could have specific challenges in tracking low and moderate-income populations, and fulfilling the ACA objective of the exchange providing timely information about eligibility for both public and private insurance. Equally critical is the timing of the data transmittal to ensure consumers will have access to accurate and reliable information about eligibility, coverage options and the cost of those options.

In addition to the technology architecture, there is a need for uniformity in order to standardize the format and language of forms that will be used to communicate certain data elements. This includes ensuring that consumers have access to useful, accurate and understandable information. The NAIC is currently working on standards for definitions and templates that will assist in this process and we encourage the NAIC to continue its work in this area to provide leadership with respect to standards by which information is communicated.